

225 years, the Guard has stood in the gap for us. I hope we will choose to stand up for them.

PATIENTS' BILL OF RIGHTS: EMPOWERING PHYSICIANS AND THEIR PATIENTS

The SPEAKER pro tempore. Under the Speaker's announced policy of January 3, 2001, the gentlewoman from Connecticut (Mrs. JOHNSON of Connecticut) is recognized for 60 minutes as the designee of the majority leader.

Mrs. JOHNSON of Connecticut. Mr. Speaker, I rise in strong support of the Fletcher-Peterson-Johnson bill, and I appreciate the opportunity to talk to people about the strength of our approach to providing people with the right to sue if they have been harmed by a plan or a decision that their plan made. It is absolutely wrong for an HMO to have the power to deny needed medical care to a participant in that plan. That is something that, frankly, we all agree on.

What we do not agree on exactly is the process by which we achieve that goal. I want to make sure that at the same time we provide patients with a right to sue their HMO, we do it in a way that returns power and control over our health care system back to physicians. I do not want a solution to patients' rights that empowers lawyers over doctors, or puts in place such a complex system that resources hemorrhage out of our health care system into our legal system, diminishing not only the rights of patients but the possibilities of those who participate in plans for medical care.

Mr. Speaker, I think through this discussion tonight we can make clear that our goal is to empower physicians, to return control of our health care system to physicians and patients, to doctors and the people they care for, where it ought to be; and to make sure that in the process of reform, we create new rights of access, we guarantee a new and objective external appeal process, but we do not transfer power that plans now have and should not have to lawyers for them to have, when they should not have it. So this is all about patients' rights and doctor power, and that is what we want to talk about tonight.

Mr. Speaker, I yield to the gentleman from Kentucky (Mr. FLETCHER), who is the lead sponsor of this legislation.

Mr. FLETCHER. Mr. Speaker, I thank the gentlewoman. I certainly appreciate all the work that we have done together and the gentlewoman's help in making sure that we have a piece of legislation that truly is focused on patients and focused on getting patients the health care that they need.

Mr. Speaker, all of us have heard the tragedies of HMOs, and there are many out there, and I think we can all relate

to that. As a practicing family physician, I remember many episodes where I had a conflict with the HMO, trying to get the treatment that the patient needed. So I think all of us agree that there are tragedies out there where patients did not get the treatment they needed, or where they were misdirected to a distant ER and something happened. We want to make sure that we correct those problems and that we get patients the care that they need.

That is why when the gentlewoman from Connecticut (Mrs. JOHNSON) and the gentleman from Minnesota (Mr. PETERSON) worked on this bill, and a number of others who have worked very hard on it, we focused primarily first on patients and getting the care. We wanted to make sure that we no longer saw a system where insurance bureaucrats made medical decisions but rather physicians made medical decisions.

We also did not want to go to the extreme of other folks saying, let us let lawyers and judges make the medical decisions. That is not right either. First off, the ability to get that treatment is impaired. It may take years to get a settlement, well after the medical treatment is needed. Secondly, judges and lawyers are not trained to make those medical decisions. So we established a bill that focused on getting the care patients need.

Now, let me compare, because I have a chart here that compares the basic elements of the patient protections in the two bills. Our bill, which is the Johnson-Fletcher-Peterson bill versus the Ganske bill, or the Kennedy-McCain bill. First, emergency access. We both ensure that the patient can get the emergency room care that they need.

We also ensure something called point of service. What that means is that one has an option of going to any physician. If one wants to get that plan, one can go to any physician out there. They may not be a physician that is part of even that network of the HMO, and a company will offer a plan that you can purchase that will allow you to see a physician that you trust that may not be a member of that network. You can see your OB-GYN doctor directly. You can take your children, and I know that this is very important for families, to ensure that their children have access to that pediatrician that has been trained especially to take care of the problems of children. We provide direct access to pediatricians.

Specialty care. To make sure that there is an adequate coverage of specialists out there to bring the latest, the state-of-the-art of medicine, to the patient's bedside. We want to make sure that there is continuity of care, that if, all of a sudden, the contract is removed from the physician, that there is a solution.

For instance, if you are a young lady and you are being covered by a physician or he or she is your attending physician and you are about to deliver a child, we make sure that you can continue that continuity of care, that you can continue to see that physician, and that you get the care that you need throughout, even though they are no longer working with that HMO, that they can do that until the delivery is completed and postpartum care is completed as well.

We do not allow any gag clauses. We do not allow HMOs to tell physicians, you cannot tell your patients what medical treatment they need. So we stop all of that, just like the other bill.

Clinical trials. We make sure that if there is a clinical trial that is out there that may give someone a hope of a cure for a disease that we make that available.

We make sure that you get plan information, just like the other bill.

We make sure that there is an appeals process; that if an HMO says, we do not think that is covered, that you can get an internal and external appeal. What does that mean? That means that you can appeal it to a panel of experts. We have set quality number one in this bill. We have established a criteria for this external review, the highest standards in the country, a consensus of experts of national opinions and what we call the referee journals, those medical journals that drive the state of the art of medicine. So we establish the highest quality of any bill. Actually, our quality of care standards are higher than any other bill here.

We make sure that the prescription drugs that you need are there, that if it is not on the formulary and you cannot tolerate the drug that is on the formulary, that there is access to a drug that may not be on the formulary, but because you cannot take the medication that is on the formulary, you get another medication.

We make sure that there is the liability, that there is the redress so that one can hold HMOs accountable.

Now, one way we hold them accountable is we make sure that if an insurance company does not comply with this panel of expert physicians, this high gold standard, that if they do not comply with that and give the treatment that one needs, we hold an HMO liable in exactly the same manner that a physician is liable.

The other side has about 19 pages of criteria that have to be met. Nobody knows how the States are going to respond to that. We are seeing a decision from the Department of Justice saying that we are not sure how the States are going to respond to 19 pages of Federal mandates on State courts. That is unprecedented. But we make sure that the HMO is held accountable if they do not comply with those panel of expert

physicians, the same way a physician is held accountable.

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There is no difference in our bill. We make sure that there is tight, focused accountability.

We also provide, and let me talk about it, immediate access and instant remedy. When we focus on patients, that is what we want to see.

We also provide the opportunity for small businesses to come together and to offer a national health plan. That will save an estimate of 10 percent to 30 percent on premiums.

I have not talked to anyone out there, Mr. Speaker, that is not interested in the cost of health care and of seeing that going up double digits this year. So being able to decrease the cost of health insurance, make that more accessible, allow more small businesses to offer health insurance is one of our goals. I believe we accomplished it.

It is estimated that 8.5 million Americans will be able to get insurance that do not have insurance today. We hold HMOs accountable; and we weed out bad players, as I have said. We make sure that the medical decisions are made by doctors.

The Kennedy bill and the Ganske-Dingell bill, what they say is that if one does not get the treatment immediately, if they just allege harm, they can go to court. What does that do? That does not, first, get the patient the treatment they need, and it also increases the number of junk or frivolous lawsuits. We will talk about that in a minute and what effect that has on patients' ability to get affordable health care.

We make sure that one does not have to go to a judge, that one can go to a doctor to get an opinion. Then if the HMO is a bad player, we hold them accountable.

We enable small businesses, as I said, to offer health insurance. Most importantly, when we talk to the American people, Mr. Speaker, what we find out is that the American people are very, very concerned about the health care they get through their job. I have some farmers in my district whose spouses go to work simply so they can get that health care.

The other bill may impact that to the point where individuals will lose the health care they get through their work. In Kentucky, that estimate is 40,000 to 80,000 Kentuckians will lose their health insurance because of the Ganske-Dingell bill.

Again, we protect the health care Americans get through their jobs. We provide all patients with patient protections. By setting that gold standard by that independent review of panels, we raise the standard of the quality of health care.

When we look at insurance premiums, ours, when we figure the total

bill with those association health plans and something else called Medical Savings Accounts, where one can set aside some money to use for health care expenses, ours shows that we will have a net decrease, if we look at the premiums. Theirs will increase by about 4.2 percent.

We do not think we will increase lawsuits. Actually, we will get the care and have less lawsuits than they will, but yet we will weed out bad players.

We estimate that we may decrease totally by 7 million the number of uninsured. They may increase it for some up to 9 million.

Health care quality, we believe we can actually increase health care quality with this bill, which is a primary concern.

We want remedy, we do not want retaliation. We know there is a lot of emotion. As a physician, I can say there are many times when HMOs angered me. But the motivation for passing a good patients' bill of rights is remedy, not retaliation. We want to make sure one gets immediate help, not unlimited or frivolous lawsuits.

We want to make sure one has access to State courts if the managed care company refuses to give what the experts say. There are no caps on many of their decisions, and that means premiums are going to go up. We have access also to Federal courts if it is a coverage decision.

Why is it very important to make sure that we provide health insurance? Why are we so concerned about the uninsured? I am disappointed in the other side. I think we both have a very similar motive, but their bill has what I call truly a flagrant disregard for the uninsured.

When we look at the simple fact, and this comes out of the Journal of American Medical Association from November 19, 1997, this was an article that said that a patient without health insurance is three times more likely to die than patients with health insurance. So when we talk about driving up the number of uninsured, we have a tremendous impact on the health and well-being of Americans. That is why it is so important to focus on the uninsured.

Look at this map. We currently have 43 million Americans uninsured. If we look at, under the Ganske bill, there are 4 million more uninsured. If we look at the blue States and if we were to take the population of all those blue States, that is equal to the population of the number of people in the United States that have no insurance. That is where we should be focused.

That means that 43 million Americans now are not able to go see their physician, not able to get the preventive health care they need, so when they do arrive in the emergency room their disease is further along. It is more advanced and less curable.

If we pass the Ganske-Dingell bill, it is estimated that those red States, a population equal to the population of those red States would lose their health insurance. I do not think that is something we can afford in America.

Let me say this, as we look at the differences, I think both of us have the same goal. That is to make sure we provide good patient protection. I think in their liability portion they are very misguided in the sense they turn decisions over to judges and lawyers instead of physicians. I think it is bad legislation, particularly for those that I call "near-uninsured."

Who is it going to impact most? Low-income and minorities, that is who it is going to impact. I am surprised that the Democrats would take up this issue, because that is a constituency they always speak about having compassion for, yet their bill will impact them worse than any other portion of our society. Low-income and minority people are the ones that stand to lose the health insurance, those who are barely getting along, those families who are having to decide between putting food on the table and providing health care for their children.

Under their bill, they may end up having to say, I am not going to take the food off the table, so I will have to drop health insurance. That is not right for America. That is not good for those most vulnerable in our country.

I appreciate the opportunity, I say to the gentlewoman from Connecticut (Mrs. JOHNSON), to speak with her, and I thank her for all her work on this bill. I think we have an excellent bill. I thank the gentlewoman for the opportunity to share this time with her.

Mrs. JOHNSON of Connecticut. Mr. Speaker, I thank the gentleman for joining us.

I want to ask just one question to the gentleman, as a physician. Is it not true that under our emergency services section, where we guarantee people the right, if one's pain is severe enough that any prudent layperson would think someone needed to go to the emergency room, they can go to the emergency room and get care under our bill and under the other bill?

But there is a unique aspect to our bill. That has to do with very, very young infants, where of course "the prudent layperson" rule is a little hard to apply. So we do take a different tack in that portion of the bill. If the gentleman would just talk about that, I think it would help people understand how thoughtful our legislation is.

Mr. FLETCHER. Mr. Speaker, we wanted to make sure that the access there to the emergency was available to everyone, regardless of their age and regardless of their ability to be able to define what a layperson's definition is.

So we make it very clear, and I think that is one of the reasons that, when we talk to the emergency room physicians across this Nation, they prefer

our provisions, so that no patient is without access to the emergency room.

I mentioned in the beginning that some of the problems have been that a patient may call the HMO and they send them to a distant emergency room. We have eliminated that problem. We have solved that problem. We make sure that if one has an emergency, if one has severe pain or something where one feels or a layperson feels like it could threaten their health, they can go to the nearest emergency room, get that treatment from those physicians and health care providers, and they can be assured of being reimbursed for that.

Mrs. JOHNSON of Connecticut. If they have a very sick infant and go to the emergency room, and in the opinion of the health professional, the prudent opinion of the health professional, that infant needs certain care, that infant can have the care that they need on the word of the health professional, as opposed to the prudent layperson's standard that pertains to me, if I were in pain or another adult if they were in pain.

Mr. FLETCHER. Let me address this. A young mother sometimes is not sure whether an infant needs to come. I recall a situation where a young mother came and she gave me, after a few questions, a short history of this infant. She was not sure whether or not that infant needed to come in.

At that point, I told her that, no, I think you need to come in immediately. When that child arrived there, it was very, very ill. The gentlewoman is absolutely right that it is very difficult sometimes on a layperson's judgment to define whether a young infant, a very young infant, is truly at a great deal of risk with their health care, and yet it requires health care professionals.

So our provision for that gives a lot more protection to those young mothers and young infants.

Mrs. JOHNSON of Connecticut. Mr. Speaker, I thank the gentleman very much for his time tonight. It is a pleasure to know that the emergency physicians were very involved in writing that provision, and we have very strong coverage and protection for emergency room care.

Mr. Speaker, I yield to the gentleman from Georgia (Mr. COLLINS), from the Committee on Ways and Means.

Mr. COLLINS. Mr. Speaker, I thank the gentlewoman for yielding to me.

I really enjoyed the explanation of the gentleman from Kentucky on the health care provisions in both plans. That is what people are concerned about at home, that they want to better understand their health care insurance, what their coverage is, and what the plan consists of, more so than anything else.

I have very few, and I cannot recall any, really, who have been to my office

and said, "Mac, I want you to pass legislation to let me sue my insurance plan and my employer." That is not what is on their mind. What is on their mind is the information that the gentleman from Kentucky (Mr. FLETCHER) shared with us: "What am I going to do about health insurance and health care coverage for me and my family?" Those are the concerns.

I have very few to call the office concerned about the denial of a service that they may need in the private sector. I do have quite a few calls when it comes to some of the, what I will call government-run HMOs, health management organizations, and those are Medicare and Medicaid.

Thanks to the new administration and some of the things that are happening over at the Center for Medicare Services now, though, those calls have become fewer and fewer.

We used to have a lot of calls about the Veterans Administration, but fortunately, we have had a lot of good, positive changes, especially in the Atlanta Region, with the VA. I have not received, in years, many calls.

These are things that, as a Member of Congress, it is pleasing, because I feel like my constituency is being better served by those particular agencies.

I say to the gentlewoman from Connecticut (Mrs. JOHNSON), there are a couple things I do have complaints about. One is the cost of health care. People say, "Congressman, why is my health care so high? It is to a point where I cannot afford it. Why is insurance so high? I cannot afford coverage. I cannot afford the insurance. What am I going to do? What am I going to do?"

One thing we should not do is subject the marketplace to provisions of law that may increase those numbers who cannot afford insurance or cannot afford to pay their health care costs. That is just something we do not need to do. I am afraid what we are looking at with this particular patients' bill of rights is the fact that we may increase, if we pass one particular provision, and that is the bill that the other parties have offered, the Ganske-Dingell bill, the McCain-Kennedy bill, that possibly we will increase the number of uninsured and raise the cost to a point that many cannot afford it.

I have had health care management organizations to come by the office in Georgia, particularly the Jonesboro office, because it is closer to the Atlanta area, and talk to me, it has been 3 or 4 years ago, about health care and what they were going to do, how they were going to take care of the uninsured. One had some pretty slick brochures, they were just fancy, and they probably spent a lot of money on preparing them.

I looked at them. We talked for a while. I said, "These things are pretty. They are slick. A lot of good information here. My advice to you is to do

what you say you are going to do in these brochures, and that is take care of those that you insure." I said they should heed the warning, because if they did not, there was going to be legislation before the Congress that will make them wish they had. That type of legislation I do not believe will be good for the marketplace, for those who are uninsured, or those who insure.

Some companies have heeded that warning and made some changes, but many have not. I think the marketplace is where things should take place and where the reform in HMOs should take place. Employers, as they select plans, they select plans based on competition in the workplace for employees. It is a benefit. Some plans are better than others because some businesses can pay better than others.

Labor contracts, many times labor in their negotiation will use health care coverage as part of their negotiation or their leverage. Insurance companies themselves providing insurance, they are competitive. They are competitive businesses.

There is not just one insurance company, like we have with the insurance for our seniors, Medicare, or insurance for the poor, Medicaid. There are a lot of private sector insurance companies who compete for business. They compete on the basis of what they have to offer, the price of what they have to offer, and the satisfaction of those who receive the coverage under their plans.

That is where the HMO reform should take place. That is the marketplace. But it is not. It is taking place right here in the halls of Congress. It worries me.

We have, as we all know, the patients' bill of rights. Unfortunately, as I hear the coverage at home on the national media, they do not talk about provisions that the gentleman from Kentucky (Mr. FLETCHER) talked about. They talk about "this bill is all about people have the right to sue the insurance company."

Do Members know, I believe they have that right today. If someone is harmed by another individual, whether that individual is an entity or is a person, they have a remedy of law. They have a right to recover.

I do not think what we are doing here is absolute in what we are trying to do as far as the marketplace is concerned. We have a choice, as I mentioned earlier. We have the Ganske-Dingell bill.

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A lot of people at home know it as the Norwood bill, very similar to the one that passed over in the Senate. But I have to say that, based on my experience in business, my experience of having been in the Congress now for 8½ years, my understanding of people and a common sense approach to this issue, I do believe the gentlewoman has the better approach of all that has been

presented. I believe it has a less negative impact on employers. I believe it has a less negative impact on employees.

Let us face it, most people obtain their health care insurance coverage at the workplace. That is where it happens. That is the benefit. That is the incentive that an employer offers to have someone work for them, or part of the incentive program. And the gentleman's bill puts at risk in a lesser fashion the employer when it comes to liability. As an employer for 38 years myself and in the type of business that I am in, trucking, have been since I was 18 years old, a lot of miles on the road, a lot of employees in accidents, I have been in court, and it is not cheap to go to court to defend yourself.

I know that a lot of employers, if they are going to have to subject themselves to additional cost, the additional time and trouble of defending themselves based on a suit that may not be a viable suit, it may not be a real liability to them, but they have to go to court to prove that it is not or to have themselves removed from the case, what will happen, I am afraid, is that many employers will just say, hey, I am not going to do this. I am just not going to provide it.

What if they do? What if they say, I will continue on. I will take that chance. What will be the result? I think it will be based on passage of legislation, whether it be either bill. I like the idea that the gentleman from Kentucky (Mr. FLETCHER) put forth, that this may actually reduce costs, and I hope it does. I think the majority of the time, though, anytime the Congress gets involved in something, it always increases the cost, whatsoever it may be.

But let us just look at a couple of comments that a group on Wall Street made about the potential of the McCain-Kennedy, or the Kennedy-McCain, now that the Democrats are in the majority over there in the other body, or the bill that is before us from our side, the Ganske-Dingell bill.

These are the four things that they say could happen. They say, first of all, if the President were to sign either one of those two bills that they think that, similar to some insurance companies that are already out there, that they would just draw language for their plans that would more carefully and extensively exclude areas of services, regardless whether they are medically necessary. They would exclude them by taking out the words "medically necessary."

They think that the plans would eliminate preauthorization so that they would not have to delay or deny care but merely make retrospective coverage decisions on claims after the care was rendered. Now, how would my colleagues like to get a notification saying, wait a minute, that \$100,000 op-

eration you had was investigative surgery, because the words medically necessary are no longer there? That would be stunning. It would be to me, anyway.

Third, this group thinks that plans would raise premiums and fees to address potential costs of expanded liability and other patient bill of right provisions.

And, fourth, businesses will adjust. If they decide to stay in the marketplace and provide the incentive for their employees, they will make the adjustments. I know they will. I have been there for 38-plus years and have made a lot of adjustments based on government regulations.

They say that we think the sponsors, those who buy and make the decisions to purchase the insurance, would increase the beneficiary costs, the employees' cost with cost sharing, with higher deductibles, or coinsurance, or co-payments to offset such increases. So it will cost employees as well as possibly employers.

The Ganske-Dingell bill, and I hate to take up so much of the gentleman's time here, but this thing has been bothering me for a long time and I just have not spoken out much on it, but it has bothered me as a Member of Congress and as an employer. They say employees are protected, but are employers protected? If they are, why do we not just say so with maybe some language that says the decision to purchase health insurance as an employee benefit is not subject to liability, because it is not a health care decision. Now, the gentleman has. The gentleman has accepted that type of language very similar to that, and that is good language because that protects that employer and the employee by not discouraging the employer to stay in the marketplace.

I say to my colleagues, let us not jeopardize the insured that are out there today by jeopardizing the employers, their workplace; not only jeopardizing them for the possible loss of insurance coverage but jeopardizing from the standpoint that their share of the insurance coverage for their families more than likely will be increased.

Well, that is all I am going to say for now, but I appreciate the gentleman's thoughtfulness. I know she has worked diligently on this legislation, and I hope that my colleagues will work and pay close attention to how this whole process will affect employees, insured, and employers who provide the coverage as a benefit.

Mrs. JOHNSON of Connecticut. My colleague, the gentleman from Georgia (Mr. COLLINS), has made a series of very important points, but the most important point is that health insurance is the most important benefit that employees receive from employers and that in fact the only place people can get affordable health insurance is through their place of employment.

If we provide access to specialist care and all of those access rights that we provide in this bill, which both bills provide and which do not in themselves cause any of the problems the gentleman is talking about; and if we provide a national process of independent review of decisions made by insurers to guaranty that those decisions do not deny needed care, which both bills provide and 41 States provide, that will not have the consequences that the gentleman fears. But if we provide the right to sue wrong, we will have the consequences the gentleman fears. And if businesses think they can be sued for what are essentially malpractice decisions, they will drop their plans or increase costs.

Just to give my colleagues a little example of how important this is, in last year's alternative bill we had a system for protecting employers. The employers, frankly, did not think we were right, and they did not support it. But it was the best we could think of at the time. It said if you did not directly participate in the decision, then you could not be sued. But direct participation turned out to be a pretty long chain, and a lot of people got swept into it.

So this year, as we move forward, we thought harder about that issue of protecting the employer, who, after all, is only doing his employees the good service of having a plan and paying for it for them. So we came up with a new way of protecting employers. And one of the things about our bill, the Fletcher-Peterson-Johnson bill is that it has a simple, clean mechanism for protecting employers. The employer simply appoints a dedicated decision-maker, and under his plan he then is protected from suit.

Now, in the other bill, realizing what a good idea we had, in the Senate they added that designated decisionmaker into the bill. But they just laid it on top. So now their bill has two systems. What that does is to create court cases about which system. That is the kind of way in which the other bill, in its complexity, invites litigation, explodes litigation, drives up costs, drives up premiums or copays, or reduces coverage or, in fact, forces employers to drop their plans.

So when we talk about the fact that our bill better protects employers and protects the employees' insurance, it is right there in black and white. It is in the provisions. Their provisions drive inappropriate litigation. Our provisions only help the person who was harmed by not getting the medical care they deserved. And that person, under our bill, has the right to sue.

I thank the gentleman from Georgia for joining us and talking about this.

Mr. COLLINS. If the gentleman will yield further, they should have that right, and I think they have that right today.

I am still very concerned about the language, though, of appointing a decisionmaker. Because that can be questioned, too. But if the decision to purchase the insurance is not subject, because it is definitely not a health care issue.

Mrs. JOHNSON of Connecticut. That is right, and that is very clear under our bill, that that is not a health care decision.

Mr. COLLINS. Well, I hope it is, and I think it is, because I have been assured that that is my amendment that the gentlewoman has accepted. I thank her.

Mrs. JOHNSON of Connecticut. That is right.

Now, I would like to recognize my colleague from Arizona (Mr. HAYWORTH), also a member of the Committee on Ways and Means, and I appreciate his being with us tonight.

Mr. HAYWORTH. Mr. Speaker, I thank the gentlewoman from Connecticut for yielding to me. I listened with great interest to the gentleman from Georgia and, preceding me in this well of the House, the gentleman from Kentucky (Mr. FLETCHER), the principal sponsor of the true bipartisan Patients' Bill of Rights. Because make no mistake, my colleagues, we have a clear choice on this floor for all of America later this week: Will this House stand for a true patients' bill of rights or, in the games of special interests, will this House, instead, pass a trial lawyer's right to bill.

The gentleman from Kentucky made the case. The gentleman from Georgia made the case. Let us reaffirm the principles so important to us. As I see here tonight we are joined also by the gentleman from Pennsylvania (Mr. ENGLISH), whose district, as most districts in this country, really embraces the work ethic and the notion of getting one's money's worth and the quality of life, and I think these underlying principles form the foundation of our actions.

Number one, when someone is sick, they do not go to see a lawyer. They want to see a health care professional, a health care provider of their choice, a doctor to help them solve that problem.

Number two, should there be a dispute about insurance, most individuals want health care professionals who understand the concept of continuity of care, who understand the concept of the illness that that person faces making decisions, rather than ending up in court.

The basic thought, Mr. Speaker, is this: We all want help from medical professionals rather than a court date that can stretch on and on ad infinitum instead of getting quality health care. That is the key decision we confront.

Mr. Speaker, I was frankly amazed to hear my good friend, the gentleman

from Illinois (Mr. DAVIS), come up a bit earlier this evening and talk about the profit motive and the evils that were imputed to profits. Because were we to follow the line of reasoning as relevant as headlines in The New York Times of 3 weeks ago, how shocking was the news we had about the trial lawyers' lobby and the dispute involving the Ford Motor Company and the Firestone Tire Company. The New York Times, not exactly a conservative journal, the New York Times pointed out that the trial lawyers involved in that case made a conscious decision to conceal the facts. To help protect public safety? No, to protect their case in court. And almost 200 fatalities resulted in the time from the discovery of the defect until the courtroom shenanigans to get a big decision.

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When we talk about the common interest in the public health and public welfare, who is culpable there? I say we better not go down that path, we better not surrender health care rights to the trial lawyers' lobby. Yet, the choice we will have on this floor is crystal clear.

We can succumb to the siren song of the clever and those who wrap their message of higher fees in the language of love and counterfeit compassion; or, instead, we can vote for a bipartisan measure, the principal architect of whom has dealt with patients in his primary calling in life in a bipartisan way to focus on health care for Americans. That is the simple choice when we take it all away. Are we for lawyers or are we for doctors and health care professionals helping Americans make the right decisions for their health care? That is what we will confront this week on the floor.

Mr. Speaker, I yield back to the gentlewoman from Connecticut (Mrs. JOHNSON).

Mrs. JOHNSON of Connecticut. Mr. Speaker, I think the gentleman from Arizona (Mr. HAYWORTH) is absolutely right. This is about whether doctors will regain control of America's health care system.

At the hearing before our subcommittee of the Committee on Ways and Means, every single example that the trial lawyers gave could have been solved more rapidly under the system in our bill and for \$50.

I ask, what is in the patients' interest? What is in the patients' interest is that they get the care they need and they get the care they need when they need it, that they do not go to court and face the long dragged out process of the court and face the high cost of a court case.

It was really sad to sit there and hear every single example the trial lawyers' representatives gave and to see how this could have been resolved so much more rapidly, with so much less suffering and harm on the part of the pa-

tient and their whole family and of the caring physician under our system.

My colleague is absolutely right. This is a big vote about whether patients and doctors are going to be at the heart of America's health care system in the future.

Mr. Speaker, I thank the gentleman from Arizona (Mr. HAYWORTH) for joining us today. Mr. Speaker, I welcome my colleague from Pennsylvania (Mr. ENGLISH), who has been very active in so many issues that touch on the heart and life of the people of his district, to this discussion.

Mr. ENGLISH. Mr. Speaker, I want to thank the gentlewoman from Connecticut (Mrs. JOHNSON) for yielding to me. I particularly want to thank her and the gentleman from Kentucky (Mr. FLETCHER) for their leadership along with the gentleman from Minnesota (Mr. PETERSON) in moving this debate forward.

I believe that the House is going to make a momentous decision in the next few days. A decision which could either lead our health care system forward on a path of quality or, on the other hand, could lead to an unraveling of our longstanding system of health care based on employer-provided benefits. My fear is that the House may make the wrong decision. But thanks to the heroic efforts of the gentlewoman from Connecticut (Mrs. JOHNSON) and the gentleman from Kentucky (Mr. FLETCHER) and others, there is an alternative, a commonsense alternative.

Mr. Speaker, I came to the House in 1994 as an advocate of health care reform. I have concluded, Mr. Speaker, that today the best medicine for patients is a modernization, an improvement of the health care systems for all Americans, while at the same time having an initiative to make it more affordable and accessible. We must make sure that our health care system works while preserving competition in the free market. Every family deserves health care that can never be taken away.

Congress must move this week to adopt health care reform that moves us down the path toward universal access to affordable care. In my view, the version of the patients' rights bill of the gentleman from Kentucky (Mr. FLETCHER) is the one that does precisely that. I am an original co-sponsor of this bill because it recognizes that strengthening patients' rights is the first and seminal step to successfully reforming health care.

Mr. Speaker, I am urging all of my colleagues tonight to back the Fletcher bill because ensuring patient access to affordable quality health care should be the focus of any reform effort. We need to put patients back in charge. That means establishing quality standards for all health plans, allowing doctors and patients to make health care decisions.

Mr. Speaker, I am happy to say that after years of examining managed care reform legislation and as a member of my colleague's subcommittee, a great deal of consensus exists as to what a Federal patient protection bill should include. I believe there is also strong bipartisan agreement that Congress should act quickly to extend patient protections to all Americans. The plan of the gentleman from Kentucky (Mr. FLETCHER) does exactly that, by providing patients with the tools they need to protect themselves and to ensure that they have quality health care coverage now and in the future.

This bill provides patients with better access to information about their health care coverage. It requires plans to provide patients with detailed plan information with an explicit list of covered and excluded services and benefits.

Unlike other proposals, the plan of the gentleman from Kentucky (Mr. FLETCHER) requires the plan to disclose their formulary if requested. H.R. 2315 reopens the door that allows patients and doctors to work directly together to decide the best course of treatment, rather than focusing on insurance company guidelines and regulations. It ensures that patients have the right to choose their doctor with continuity of care protections. These protections allow patients who have an ongoing special condition such as cancer or even a pregnancy to have continued access to their treating specialist in cases where the specialist has been terminated from the plan or if the plan is terminated.

H.R. 2315 eliminates the so-called gag rule by prohibiting health plans from restricting physicians giving patients advice about their health and what is the best for them. Additionally, this legislation does not forget the special health care needs of women and children by allowing immediate access to gynecologists, obstetricians, and pediatricians. It also provides access to specialists.

The bill of the gentleman from Kentucky (Mr. FLETCHER) provides a provision that says patients cannot be denied emergency care coverage because the visit was not preapproved. The plan says if a prudent layperson believes that a symptom requires immediate medical attention, including emergency ambulance services, then the insurer must pay for the care regardless of whether it is a network facility. We do not want to let insurance providers drive the industry to a point where, in an emergency, patients are calling their insurance companies before dialing 911.

The plan also requires coverage of routine medical costs for patients enrolled in any government-sponsored cancer clinical trial which includes FDA trials under which about two-thirds of all clinical trials occur. It

also prohibits insurance providers from denying coverage on FDA-approved drugs or medical devices by classifying them as, quote, "experimental" or "investigational."

This legislation provides patients with the best access to prescription drugs by allowing doctors to request off-formulary drugs for their patients and for plans to consider side effects and efficacy in their determination.

Mr. Speaker, American families are concerned about their health care; but we cannot address the quality of care without addressing the cost. Those without health insurance are not just the indigent. It is the small business owners, the self-employed who cannot afford the premiums. It is young people. It is a broad cross-section of America. A staggering 44 million Americans cannot afford or do not have health insurance.

Studies show that other proposals being offered in the House as an alternative to the bill of the gentleman from Kentucky (Mr. FLETCHER) could force 6 million more Americans into the ranks of the uninsured. On the other hand, studies show the plan of the gentleman from Kentucky (Mr. FLETCHER) would help provide 9 million uninsured Americans vital access to coverage by expanding association health plans and repealing all restrictions on access to medical savings accounts, tax-favored accounts that give the patients themselves ultimate control over their own health care.

Another notable feature that puts the proposal of the gentleman from Kentucky (Mr. FLETCHER) above the other proposals which claim to protect patients is support from the Bush administration. President Bush has promised to sign this bill saying, "I believe the Fletcher bill will help enhance the great medical care that we have in our country."

I could not agree more, and I am pleased that the President has put the needs of patients first by lending his support to this bill. Health care reform is complicated, much more complicated than many would have us believe. We must protect patients by advocating strong patient-focused health care reform.

Mr. Speaker, I will reiterate, strengthening patient protections, strengthening patients' rights is the key to reforming health care. I strongly support H.R. 2315. I salute the gentleman from Kentucky (Mr. FLETCHER) and the gentlewoman from Connecticut (Mrs. JOHNSON) for their efforts.

Mr. Speaker, I support this as a plan to reform managed care that promotes quality care and restores the doctor-patient relationship. My hope is that my colleagues can join us in rallying behind this initiative as a bipartisan basis for moving finally a patients' bill of rights forward, moving it back to the Senate, and getting a consensus

that we can get a Presidential signature on.

I believe this is all achievable in the immediate future if we can work together on a bipartisan basis in this body. I thank the gentlewoman for playing a critical role in creating that bipartisan environment that is allowing us to move forward and have this vote and hopefully move forward to success.

Mrs. JOHNSON of Connecticut. Mr. Speaker, I thank the gentleman from Pennsylvania for his comprehensive remarks on this issue. This is an extremely important debate we are going to have. I personally believe that every patient, everyone who has health insurance and needs medical care, has the rights of access to quality care that are guaranteed in our bill and in the other bills. That is the right for a woman to choose an OB-GYN specialist, the right to choose pediatric care, and other specialists, to emergency care, to continuity of care, to access to proper information about one's plan, access to treatment under clinical trials, something I fought 5 years for for Medicare recipients so they could have the benefits of clinical trials, protection from gag rules, and things like that.

These patients' rights embodied in our legislation are extremely important. Yes, they can only be enforced if a patient who is denied access has the right to sue. I am proud to say that in our bill, a patient who is denied needed care and harmed by that decision has the right to sue and gets redress. But the program we put out to guarantee patients the right to sue under our bill is a legal structure that is simple, that is direct, that makes it clear to employers that they cannot be sued if they are not making medical decisions; and, therefore, it is affordable and will not push costs up.

Mr. Speaker, we limit liability in a responsible fashion, just as they do in Texas and in many, many States that provide the right to sue. By doing that, again, we control costs and we protect the employers who are the primary folks who are providing health insurance to the people of our country.

Mr. Speaker, I am very proud that the gentleman from Kentucky (Mr. FLETCHER) and others have been part of the team that have developed this legislation, that it offers to the American people all of the access rights, all of the protections they need to both continue to enjoy health insurance through their place of work and to have the right to all needed medical care. This is a patients' bill of rights. This is a doctor-power bill.

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But if we do this wrong, if we do not really listen to what might happen if we write these provisions in a way that is insensitive to what happens when

frivolous suits are brought to the table, when costs shoot up for all the wrong reasons, then in fact we will do damage to the rights of patients and we will deny many currently covered the great privilege and pleasure of health security through health insurance.

I enter this week with high hopes that we in the House can do the right thing to provide access and care to all who have insurance. I am proud to say that the American College of Surgeons, the College of Cardiologists, the thoracic surgeons, the orthopedic surgeons, the neurologists, and I could go on and on, enough groups of doctors support this bill so that we have that same doctor power behind this bill as the AMA that supports the other bill.

But it is very interesting. The groups that support our bill are the very groups who are most concerned about patient access to their services, because they are the specialist groups. They are the ones that under the current system most frequently are not able to reach the patients that need their care.

So I am proud of this legislation. It will serve the people of America well. The bills have much in common. I hope working together we in this House and our colleagues in the other body can send to the President's desk a Patients' Bill of Rights that will serve patients, doctors and all Americans and maintain the strong system of employer-provided health insurance that has made the American health care system the best there is in the world.

MANAGED CARE REFORM FROM A DEMOCRATIC PERSPECTIVE

The SPEAKER pro tempore (Mr. KIRK). Under the Speaker's announced policy of January 3, 2001, the gentleman from New Jersey (Mr. PALLONE) is recognized for 60 minutes as the designee of the minority leader.

Mr. PALLONE. Mr. Speaker, I intend this evening with some of my colleagues on the Democratic side to focus on the same issue that the previous Republican Members focused on, and, that is, the Patients' Bill of Rights, the HMO reform bill.

I must say that it disturbs me a great deal to see some of the opponents of the real Patients' Bill of Rights, the bill that has been sponsored by the gentleman from Michigan (Mr. DINGELL), who is a Democrat; the gentleman from Iowa (Mr. GANSKE), who is a Republican and a physician; and the gentleman from Georgia (Mr. NORWOOD), who is a Republican and a dentist, and that was voted on overwhelmingly by every Democratic Member of the House of Representatives in the last session and about 68 Republican Members, the real Patients' Bill of Rights, is now being superseded on the other side of the aisle by the Republican leadership which is now prom-

ising to bring an alternative bill which they also refer to as the Patients' Bill of Rights to the floor.

I would remind my colleagues that the real Patients' Bill of Rights, the one that we voted on, one that all of us, most Democrats and a significant number of Republicans have been pushing for for probably 5 or 6 years, is the bill that should be allowed to come to the floor rather than the Republican alternative, the Fletcher bill, which is in my opinion nothing but a fig leaf and which does not accomplish the goal of truly reforming HMOs.

There are two essential goals of HMO reform that are in the real Patients' Bill of Rights. One goal is to make sure that medical decisions are made by the physician, the health care professional and the patients, not by the HMOs, not by the insurance companies; and the second goal is to make sure that if you have been denied care by the HMO that you have a legitimate and reasonable way of seeking a redress of grievances and overturning that decision so you can get the care that you need.

I would maintain, and we will show this evening once again, that the Fletcher bill does not accomplish that goal; and the real Patients' Bill of Rights, the Dingell-Ganske-Norwood bill, does.

I wanted to, if I could this evening before I yield to some of my colleagues, really point to the two major criticisms that I heard on the Republican side of the aisle tonight against the real Patients' Bill of Rights. One is that there are going to be too many lawsuits. The second is that it is going to drive up health insurance costs.

The best way to refute that is to refer back to the Texas law that has been on the books for a number of years now which is exactly the same really as the real Patients' Bill of Rights and which shows dramatically that neither one of those disasters, all these lawsuits, all this litigation, or the other disaster that my Republican colleagues talked about, that health care costs are going to be going up, that insurance companies are going to drop their patients, neither one of those disasters befell the State of Texas because a real Patients' Bill of Rights was put into effect.

It is interesting because, in reality, what President Bush is doing in the last few weeks and leading up to hopefully a vote this week on the Patients' Bill of Rights is that President Bush is waving the same flags that he used in the State of Texas when he was Governor to say there is going to be too much litigation and that insurance companies are going to drop patients and not let Americans have health insurance, that they are going to drop health insurance. These were the arguments that the President used when he was the Governor, they are the arguments that he is using now, and it is simply not true.

Mr. Speaker, if I could just give some statistics. This goes back to 1997 when then Governor Bush said of the Texas law and I quote, "I'm concerned that this legislation has the potential to drive up health care costs and increase the number of lawsuits against doctors and other health care providers." What did the President, then Governor do? He vetoed a bill similar to the Patients' Bill of Rights in 1994.

In 1997, when it came up again, he did everything he could to sabotage the bill to the point that he actually refused to sign it but I guess for political reasons figured that he could not veto it again and so he simply let it become law without his signature. But we are getting the same rhetoric again.

Last week as the Patients' Bill of Rights, the real one, made its way towards debate in the House, the President said almost the same thing; and I quote. He said, "This is how best to improve the quality of care without unnecessarily running up the cost of medicine, without encouraging more lawsuits which would eventually cause people not to be able to have health insurance."

Again, that people are going to have their health insurance dropped, that litigation is going to increase.

Let us look at the facts. Since the 1997 Texas law that Bush opposed so strongly has taken hold, the disastrous effects he had predicted have yet to occur in the Lone Star State. In the 4 years since, even the law's opponents acknowledge that none of then Governor Bush's predictions have come true. Instead of becoming a bonanza for all these trial lawyers, the right to sue an HMO or an insurance company in Texas has been exercised just 17 times. In all the years since 1997 that it has become law, only 17 lawsuits. That is an average of three or four per year.

According to the Texas Department of Insurance, the number of Texans enrolled in health insurance or HMO plans has actually increased steadily since the 1997 law was passed. Enrollment has grown from 2,945,000 Texans at the end of 1996 before the law was passed to 3.2 million at the end of 1997 to 3.9 million at the end of 2000. There is just no truth to this. In fact, when you talk about the cost, the cost of HMO premiums in Texas have risen but less than the national average. So the bottom line is the disaster has not occurred.

I know I almost hesitated to talk about what is happening in Texas because my two colleagues whom I know are going to join me tonight are both from Texas and I do not like to speak about another State, but it is all positive. The experience has been totally positive.

How can the President or any of our Republican colleagues on the other side of the aisle suggest the same kind of thing, the same kind of disaster that is